

## SECTION O – CHRONIC CARE MANAGEMENT PROGRAM

***O.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for Bayou Health. Include information on work you have conducted in other states, if applicable. Include how you measure success for each of the populations (i.e. 20% reduction in 30-day readmission rate for members with diabetes); any state models you plan to implement in Louisiana; and how you plan to partner with national, state, or community foundations to support this work.***

### Overview

Louisiana Healthcare Connections (LHCC) will continue offering its current Chronic Care Management Programs (CCMPs), as well as implement additional planned CCMPs, to meet the needs of our Bayou Health members and improve health outcomes. LHCC will continue to benefit from the substantial 30-year chronic care management experience of our parent company, Centene Corporation (Centene), which supports LHCC in program development, monitoring, information technology and other CCMP solutions.

LHCC's approach to chronic care management focuses *on the whole person*, including integrating needed covered, carved out, and community-based services. We use a multi-disciplinary Integrated Care (IC) Team to offer CCMP programs that address the needs of members with both physical and behavioral health (BH) conditions and provide

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**Our overarching goal is to help each and every Bayou Health member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results.**

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coordination with the member's primary and specialty providers since BH conditions such as depression can exacerbate, or form a barrier to, self-care for any chronic condition. BH conditions are often co-morbid in members such as those who have diabetes and heart conditions or persistent pain.

CCMP is an integral part of the range of services that LHCC provides to all members. Through our CCMP programs, we continually strive to achieve optimal health status through member engagement and behavior change motivation. Our programs do this through a comprehensive approach that includes:

- Rapid and thorough identification and assessment of program participants
- A team approach in CCMP management that includes staff with expertise and skills that span departments and services
- Information technologies that support care coordination within LHCC plan staff and among a member's providers and caregivers
- Multifaceted approaches to engage members in self-care and improve outcomes; and,
- Multiple, continuous quality improvement processes that assess CCMP effectiveness, and identify areas for enhancement to fully meet member and Louisiana priorities.

Our CCMPs use proven methods of health coaching and Motivational Interviewing to engage the member in self-management techniques. Our model emphasizes *direct member contact*, such as telephonic and face-to-face education because it more effectively engages members and allows us to provide information that can address their questions real time and better meet their needs. Participating members also receive written materials, preventive care and screening reminders, invitations to community events, and unlimited inbound access for health care and psychosocial questions and needs. Recognizing that each member's clinical condition and psychosocial situation is unique, our CCMP interventions and information *meet each member's unique circumstance*, and will vary from one member to another, including those with the same diagnosis.

Our IC Team uses TruCare, our member-centric integrated case and utilization management platform to document a member's Individualized Care Plan, interventions and CCMP clinical and assessment notes.

TruCare supports comprehensive care coordination by providing a holistic view of the member's service needs and care.

**Experienced, Louisiana-based Staff.** Nurtur's current operations include a coaching service center in Baton Rouge in which 30 certified Health Coaches are based. Staff serve the LHCC members as well as Louisiana participants in the Tobacco Cessation Trust program. Because Nurtur Health has an office in Baton Rouge, staff work closely with the local provider and health services community, including the Ochsner Medical Center and Affinity Health Group.

Nurtur's Health Coaches are licensed clinical staff, such as registered nurses, respiratory therapists, certified diabetes educators, registered dietitians, and exercise physiologists. They must have at least two years of clinical experience in their field, and together average about eight years each in serving members of all ages. Nurtur trains Health Coaches to provide expert education and motivation using a spectrum of training programs, such as Motivational Interviewing and Poverty Competency.

**Affiliate Support—Nurtur®.** LHCC will continue our relationship with our affiliate chronic care management company, Nurtur, whose Health Coaches have been a part of our IC Teams administering our current CCMP programs. Nurtur has been providing disease management for the Medicaid, CHIP and low-income populations for over 20 years and currently serves about 3.2 million Medicaid and CHIP members in 20 states. Nurtur is NCQA accredited for Patient and Practitioner Oriented Disease Management, the most comprehensive disease management accreditation available; NCQA accredited for its Health and Wellness Program; URAC accredited for Disease Management, and for its Back Pain program; and both URAC and NCQA accredited for its Asthma, Congestive Heart Failure, and Diabetes programs. The Population Health Impact (PHI) Institute also accredits Nurtur's Asthma and Diabetes programs. The PHI Institute has also recognized Nurtur's commitment to quality and transparency in outcomes reporting by awarding Nurtur its H-TAP (Healthcare Transparency Accreditation Program) Accreditation for many of its programs such as Asthma, CHF and Diabetes. Nurtur programs have also been recognized as best practices – several of these awards are highlight in the table below.

**TableA. Nurtur Program Awards**

Disease State	Award
Technology and Engagement	2013 National Health Information Bronze and Merit Awards For best Website, Monthly Wellness Postcard Series, Breakfast Buzz Health Engagement E-mail, and Overall Health Promotion/Disease and Injury Prevention Information
Asthma Management	2012 Platinum Award for Health Care Consumer Empowerment and Protection at the URAC Quality Summit and Best Practices Awards program
Diabetes Program	2012 Medicaid Health Plans of America Center for Best Practice National "Outreach Award"
Asthma Program	2012 Case In Point Platinum Award for Top Population Health/Disease Management
Asthma Management	2011 U.S. EPA National Environmental Leadership Award

**Cenpatico Behavioral Health, LLC (Cenpatico).** Cenpatico, our BH affiliate, has full NCQA accreditation as a BH Managed Care Organization; NCQA accreditation for its Health and Wellness Program; and URAC accreditation for its Utilization Management Program. Its recognitions include the following:

**TableB. Cenpatico Program Awards**

Program	Award
Managed Care Child/Family Team Facilitator Certification Program	2014 Case in Point Platinum Award
Medicaid Case Management Program: Managed Care/High Needs Recovery Center program and Managed Care/Adult Recovery Team Facilitator Certification program	2014 Case in Point Honoable Mentions
First Step Addiction in Pregnancy Program (substance use in pregnancy)	2014 Ohio Health Plan Association's Pinnacle Award
Pediatric Case Management/Complex Case Management for Foster Care	2013 Case in Point Platinum Award

### Existing Chronic Care Management Programs

To meet Louisiana priorities and members' needs, LHCC has a well-established suite of Chronic Care Management Programs that are based on Centene's extensive Medicaid/CHIP managed care experience and tailored to the unique characteristics and needs of Bayou Health members.

Approximately 3,735 LHCC members are currently participating in our CCMPs. Centene Corporation currently serves over 3.1 million members in managed care programs in 20 states: Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, New Hampshire, Ohio, South Carolina, Tennessee, Texas, Washington, and Wisconsin. Each program listed below is also used by Centene affiliate plans, some in as many as 18 states.

- **Asthma:** Our Asthma CCMP uses Registered or Certified Respiratory Therapist (RPT or CRT) Health Coaches. Care plan focus includes promoting member adherence to asthma treatment guidelines, preventing exacerbations and optimizing functional status. Coaching is provided both telephonically and in the home, and focuses on proper use and maintenance of respiratory equipment, medication understanding and compliance, improving exercise tolerance, and tobacco cessation. Member education also includes recognizing asthma symptom triggers and how to avoid or address them.
- **Congestive Heart Failure:** Health Coaches for this program are Registered Nurses with expertise in heart failure and heart disease. Care Plan focus includes promoting member understanding and adherence to heart failure treatment guidelines, medication use, and sodium restrictions as recommended by the treating physician; self-monitoring for signs of decompensation and fluid overload; blood pressure and cholesterol management; heart healthy nutrition; weight management and optimizing physical activity; and tobacco cessation. *For certain high-risk members, in addition to health coaching, we offer real-time telemonitoring of biometric data using web-based technology and in-home devices, such as a pulse oximeter, scale, and blood pressure cuff.*
- **Diabetes:** Certified Diabetes Educators serve as Health Coaches. Care Plan focus includes promoting member understanding and adherence to approaches that optimize blood glucose, blood pressure, and lipid control; medication understanding and adherence; self-blood glucose monitoring; recognizing signs of high and low blood glucose levels; nutrition counseling for carbohydrate counting and weight

#### Existing CCMP Programs

- Asthma
- Congestive Heart Failure
- Diabetes
- Hypertension
- Low Back Pain
- Obesity

#### Planned CCMP Programs

All of the above PLUS the following

- ADHD
- Anxiety
- Depression
- Hepatitis C
- HIV/AIDS
- Pain Management (formerly low back pain only)
- Perinatal Substance Abuse Disorder
- Sickle Cell

management; recommended screenings for diabetic complications; blood pressure and cholesterol management; optimizing physical activity levels; and tobacco cessation.

- **Hypertension:** For our Hypertension CCMP, the Health Coach may be a Registered Nurse, Dietician or Exercise Physiologist. Care plan focus includes promoting member understanding and adherence to medication and treatment guidelines; improving self-management skills to reduce the risk of heart attack, stroke, and kidney disease; nutrition and physical activity guidelines; and tobacco cessation. Our Health Coaches are trained on the role hypertension plays *as a precursor to heart disease*, especially in the African American population, and incorporate that understanding when working with members.
- **Low Back Pain:** Using a baseline call assessment, the Exercise Physiologist provides members with physical health coaching supplemented by psychosocial coaching by a BH Coach as appropriate. The Exercise Physiologist works with the member and member's physician to develop a Care Plan that focuses on promoting recovery from low back pain, and preventing future back pain episodes. Interventions may include instruction for development of core muscle endurance, strength, and flexibility; review of workstation ergonomics; optimization of body mechanics and posture; and a maintenance exercise program. The BH Coach works with the member and physician to develop a Care plan that addresses medication understanding and adherence, and managing pain and stress. We are enhancing this program to a Pain Management CCMP that will address all forms of chronic pain.
- **Obesity:** Our Weight Management CCM uses Registered Dietitians as Health Coaches. Care plan focus is to improve nutrition, hydration, physical activity, and lifestyle patterns to manage weight and minimize health risk factors associated with obesity. Care plans address nutritional counseling for appropriate rate of weight loss; physical activity levels to meet recommended guidelines; behavior modification for long term weight control; and education on a variety of topics such as food preparation and portion control, reading labels, strategies when eating out, the benefits of physical activity, and tips to stay motivated. *An Exercise Physiologist may also provide input related to assessing contraindications to physical activities (i.e. joint problems) and providing exercise recommendations.* In 2015, we will be adding a Pediatric Obesity Pilot program as further described below.

### Planned Chronic Care Management Programs

In addition to the existing programs described above, LHCC will provide add 7 new or expanded CCMP programs in 2015. We will build upon our current case management efforts to create a population-based, formalized CCMP program for the following conditions: ADHD, Anxiety, Depression, Hepatitis C, HIV/AIDS, Perinatal SUD and Sickle Cell. Additionally, we also will enhance two of our existing CCMP programs: Pain Management Program (formerly Low Back Pain Management) to address all forms of chronic pain and our Obesity Program to include a *Pediatric Obesity Pilot program*.

We may provide additional programs, such as the programs under development if proven effective, and new programs to meet changing conditions and risks in our member population. We will include any additional discretionary chronic conditions in CCMP reports to DHH, as required in 6.39.3.

All programs listed below are used in Centene affiliate plans. Altogether more than 53,000 members currently participate in Centene's CCMPs.

**Table C. Planned CCMP Programs**

Program	Health Coach Credentials and Care Plan Focus
<b>ADHD</b>	Uses BH Case Managers to help members diagnosed with ADHD achieve the highest possible levels of wellness, functioning, and quality of life. Care plans focus on overall reduction in stimulant medications for children, and educate members and caregivers about symptom and medication management and coping skills.
<b>Anxiety</b>	Uses BH Case Managers to teach members diagnosed with this condition (including members with cancer diagnoses or other serious/terminal conditions) about anxiety, a wide range of coping skills, and the appropriate use of medication.
<b>Depression</b>	Uses BH Case Managers to increase member/families understanding of depression and its effects and possible treatment options. Care plans focus on appropriate self-management and use of medications. Care plans also include a Behavior Activation Plan to reduce depression symptoms by gradually increasing engagement in member-identified pleasant and enjoyable activities. This program will also support members with cancer diagnoses or other serious/terminal conditions, and members with co-morbid conditions often linked with depression, such as diabetes and Hepatitis C. <i>We will refer pregnant and postpartum members identified with depression (through Edinburgh Depression scale assessments in our Start Smart program) to this program.</i>
<b>Hepatitis C</b>	<p>LHCC will use the assistance and considerable expertise of our specialty pharmacy affiliate, AcariaHealth, for this program. AcariaHealth is URAC, Joint Commission, and ACHC accredited and operates Hepatitis C chronic care management for Centene affiliates in Florida and Illinois.</p> <p>This program will use RN CMs and AcariaHealth pharmacy staff to provide comprehensive chronic care management. Our RN CMs will provide telephonic outreach, engagement, education, assessment, support, and referrals as needed. AcariaHealth will help identify participants using prior authorization requests for the dispensing of Sovaldi or Olysio as therapies for treatment of Hepatitis C.</p> <p>AcariaHealth pharmacists will also support CM coaching with clinical consultation, documentation and reporting. Care plans will focus on increasing a member's understanding of risk factors such as sharing drug paraphernalia and sexual contact; promoting medication compliance and nutrition; managing fatigue and nausea; and avoiding infection risks and spread of disease.</p>
<b>HIV/AIDS</b>	<p>LHCC will partner with the AIDS Healthcare Foundation (AHF) to use its fully NCQA accredited Positive Healthcare HIV/AIDS disease management program. AHF's program was the first NCQA accredited HIV/AIDS disease management program and is among only three such accredited programs in the U.S. AHF currently serves more than 8,500 Medicaid fee for service and managed care members in Florida and California. It also provides HIV/AIDS disease management to Medicare plans in Florida and California and Ryan White-funded case management programs in nine states plus D.C. Our Florida affiliate currently partners with AHF for HIV/AIDS disease management for its Medicaid and CHIP members.</p> <p>This program will use an RN Case Manager to create a care plan in collaboration with the member, providers, caregivers/family, and <i>AIDS Service Organization case manager</i>, if applicable. The care plan also addresses all co-morbid conditions, such as hepatitis B &amp; C, tuberculosis, and cancer. The RN Case Managers will work closely, as needed, with our other CCMP programs in which the member is enrolled. Because of the important role of antiretroviral (ARV) therapies, this program also provides <u>specialized medication therapy monitoring</u> to assist with ARV drug adherence and other co-morbid condition medication regimens. Care plan goals will also include supporting independence, self-sufficiency,</p>



Program	Health Coach Credentials and Care Plan Focus
	effective family functioning and caregiver assistance, and use of appropriate health services.
<b>Obesity – with new Pediatric Pilot Program</b>	<p>We will enhance our current CCMP to specifically address the unique aspects of childhood obesity for our pediatric members.</p> <p>Using Registered Dietitians and Exercise Physiologists, our Pediatric Pilot program will educate and empower parents/caregivers to recognize the impact they have on their children’s development of lifelong habits of physical activity and nutritious eating, and will discuss healthy habits as part of efforts to control weight and obesity.</p> <p>We also will educate children and adolescents about healthy eating, exercise and the benefits of a healthy weight using a variety of age-appropriate written, online, in-person and telephonic methods, including social media. Our Health Coaches will track, monitor, and assess growth to track changes in BMI indicative of improved health status.</p>
<b>Pain Management</b>	This program enhances our current Low Back Pain Management Program with a program that also addresses other types of chronic pain. We will use Nurtur Health Coaches (as described in the previous table) as well as our RN Case Managers and Social Workers who will be trained and certified in pain management.
<b>Perinatal Substance Use Disorder</b>	Uses BH Case Managers to promote member recovery by developing a care plan that includes treatment referrals; self-management tools, such as workbooks designed to better understand their triggers; and use of local support groups and resources. Care plans also include coordination with the member’s providers and LHCC OB Case Managers.
<b>Sickle Cell</b>	<p>We will transition our award-winning Sickle Cell Case Management Program into a comprehensive CCMP by establishing coordinated health care interventions and communications meeting all CCMP requirements. Centene’s Sickle Cell Program won a <u>Case In Point Platinum award in 2013</u> from Dorland Health for Medicaid Case Management.</p> <p>This program uses RN Case Managers to provide Sickle Cell Disease education related to inheritance patterns, disease complications, symptoms and treatment, comorbid conditions, and special issues that arise with children and adolescents. They also promote use of hydroxyurea to reduce episodes of acute chest syndrome, vaso-occlusive painful crises, blood transfusions, and inpatient and emergency department (ED) utilization. The member’s care plan focuses on services to educate members and remove barriers to improving medication adherence. We also will outreach to local experts, such as the Sickle Cell Foundation, to identify opportunities to collaborate and provide enhanced services to our members.</p>

**Additional Supports.** Members enrolled in our CCMPs have access to the wide range of services that LHCC makes available to all members, including referrals to non-covered services, tobacco cessation services, personal care services, dental value added services for adults, Statewide Management Organization (SMO) BH Specialty Providers, and community resources such as peer support groups.

Members may also enroll in other needed CCMP or Case Management Programs, such as our Start Smart for Your Baby® pregnancy management program and BH CCMPs. A few examples of LHCC programs that will be especially relevant to members with chronic conditions include the following.

**Palliative Care Case Management Program.** LHCC is developing a Palliative Care Program to serve members with cancer and other advanced chronic and debilitating illnesses who have persistent challenges with pain and symptom management. It will use an RN Case Manager and a Social Worker who are certified through the appropriate boards, such as the **National Board for the Certification of Hospice and Palliative Care Nurses** and the **National Association of Social Workers**. IC Team staff will work with the member and treating providers (and family/guardian as appropriate) to develop and monitor a care plan that meets the member’s health and psychosocial needs, recognizing the critical role of family/caregivers in supporting the member’s psychosocial wellness. IC Team staff will leverage the

expertise of our BH Medical Director and BH Case Managers in addressing behavioral health issues, such as during the receipt of stressful and difficult information. Through USMM we will provide home-based physician services when appropriate (for more information, see response to K.1).

**Hemophilia Case Management.** LHCC is testing and developing a program for members with hemophilia and Von Willebrand disease. While hemophilia is low in prevalence, the timely and appropriate use of clotting factors and other medications is critical to these members' health and quality of life. Case management can be provided two ways: in partnership with our specialty pharmacy affiliate AcariaHealth, or by using in-house Case Management and Pharmacy staff. For members who choose AcariaHealth as their medication supplier, Case Managers will inform them of AcariaHealth's care management program, which uses Registered Nurses and Pharmacists who evaluate severity levels, health literacy, risk factors, dosing, and other criteria using the National Hemophilia Foundation's Medical and Scientific Advisory Committee guidelines. LHCC's case management program will be similarly structured. *Use of LHCC's Case Management Program and/or AcariaHealth's program is not required, and left to the choice of the member and provider.*

### Measuring Success for Each Population

LHCC's overarching goal is to help members achieve the highest possible levels of wellness, functioning, and quality of life. We build our programs upon recognized clinical practice guidelines and best practices, and assess program effectiveness throughout the year.

**Clinical Practice Guidelines (CPGs).** For each targeted condition or population, LHCC builds its CCMP approach and measures of success on nationally recognized, evidence-based guidelines. For example, we draw from the American Academy of Child and Adolescent Psychiatry, the National Heart, Lung and Blood Institute, the U.S. Public Health Service, and the American Diabetes Association. Our Quality Assessment and Program Improvement Committee (QAPI Committee) reviews and adopts one or more CPGs to support each program, drawing from, or adapting, CPGs adopted by Centene, Nurtur, or Cenpatco Quality Improvement Departments. Research and input from network providers, our Medical Directors, and other plan staff also support QAPI Committee activities. Our collaboration with PCPs and specialty providers gives us feedback on local clinical practices and how to maximize acceptance of guidelines. We make CPGs available to network providers, such as via Health Coaches or the Provider Portal. We review CPGs at least annually.

LHCC assesses each CCMP's success at least annually based on clinical, humanistic, and economic outcomes. We collect and report clinical and administrative performance measure data to monitor and demonstrate adherence to clinical practice guidelines and/or improvement in patient outcomes. Performance measures include Healthcare Effectiveness Data and Information Set (HEDIS) rates, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and/or other measures as determined by DHH. We also routinely monitor utilization of services including emergency room visits, inpatient admissions and pharmacy utilization overall and by disease state. We collect and analyze data at least annually to measure its performance against established benchmarks or standards including NCQA HEDIS 75<sup>th</sup> Medicaid Percentiles and/or those established by DHH.

**TableD. Measurements of Success**

Condition	Program Measurements
<b>ADHD</b>	<ul style="list-style-type: none"> <li>• 50% improvement in scores on the NICHQ (National Initiative for Children’s Healthcare Quality) assessment, which is a modified version of the Vanderbilt ADHD assessment. The NICHQ measures: ADHD symptoms, school performance, and appropriate relationship engagement with family and peers</li> <li>• Follow-up care for children prescribed ADHD medication (measured by HEDIS)</li> </ul>
<b>Anxiety</b>	<ul style="list-style-type: none"> <li>• Reduction in symptoms of anxiety and social impairment, as measured by the GAD-7, an empirically validated self-assessment tool</li> <li>• Reduction in anxiety-related ED use</li> <li>• Increased member education on appropriate treatment including medication use, as measured by the completion of an Anxiety call series, and member self-report of impact as correlated with the GAD-7 assessment.</li> <li>• Increased communication by members with providers about condition and treatment, as measured by member report of communication with their provider, and member accessing appropriate services as verified through various sources, such as claims data.</li> </ul>
<b>Asthma<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Reduction in the use of rescue inhalers</li> <li>• Reduction in asthma-related ED visits and inpatient admissions</li> <li>• Increase in use of long-term controller medications</li> <li>• Increase in adherence to treatment guidelines and improved self-management skills as evaluated by self-reported information and claims-based metrics</li> </ul>
<b>Congestive Heart Failure<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• 75% of members taking ACE/ARB or improvement to a compliance rate of at least the baseline rate plus half of the difference between the target rate and the baseline rate</li> <li>• Adherence to treatment guidelines and improved self-management skills</li> <li>• Reduction in heart disease-related hospitalizations and ED visits</li> <li>• Improvement in exercise tolerance and reduction in fluid retention</li> <li>• Optimal lipid and blood pressure control</li> <li>• Improvement in weight control, increase in exercise, and discontinued tobacco use</li> <li>• Controlled co-morbidities (such as diabetes)</li> <li>• Increases in adherence to treatment guidelines and improved self-management skills as evaluated by self-reported information and claims-based metrics</li> </ul>
<b>Depression</b>	<ul style="list-style-type: none"> <li>• Reduction in Patient Health Questionnaire (PHQ-9) overall score with a targeted outcome of 50% reduction or score less than 10 (the PHQ-9 is an empirically validated and widely accepted self-report tool for screening, diagnosing, monitoring and measuring depression)</li> <li>• Reduction in ED utilization</li> <li>• Increased compliance with anti-depressant medications</li> <li>• Increased communication with PCPs through documented information coordination/exchange</li> <li>• Increased self-management of depressive symptoms</li> </ul>
<b>Diabetes<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• A target rate of 80% compliance with annual HbA1c screening or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate</li> <li>• A target rate of 50% compliance with nephropathy monitoring or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate</li> <li>• A target rate of 60% compliance with annual eye (retinal) exam or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate</li> </ul>



Condition	Program Measurements
	<ul style="list-style-type: none"> <li>• Increase in adherence to treatment guidelines and improved self- management skills as evaluated by self-reported information and through claims-based metrics</li> <li>• Reduction in long-term and short-term diabetic complications</li> <li>• Optimal HbA1c, lipid, and blood pressure control</li> <li>• Improved weight control, increased exercise, and discontinuation of tobacco use</li> <li>• Reduction in avoidable inpatient and ED use related to diabetes</li> </ul>
<b>Hepatitis C</b>	<ul style="list-style-type: none"> <li>• Improved compliance with Hepatitis C treatment such as Sovaldi as measured by the number of members who have completed the full dose of their prescribed medication therapy</li> <li>• Sustained virological response (SVR) evidenced by undetectable HCV RNA 24 weeks after the end of treatments</li> <li>• Reduced readmissions</li> <li>• Reduced ED utilization</li> </ul>
<b>HIV/AIDS</b>	<ul style="list-style-type: none"> <li>• Decreased CD4 cell count</li> <li>• Sexually transmitted disease screening for Chlamydia, Gonorrhea and Syphilis</li> <li>• Gap in HIV medical visits</li> <li>• Prescription of HIV Antiretroviral therapy</li> </ul>
<b>Hypertension<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Tobacco cessation: abstinence</li> <li>• Weight management: BMI &lt; 27</li> <li>• Physical activity: ≥ 150 minutes per week, when physician approved</li> <li>• Blood pressure &lt;140/90 mmHg (Monica simply said: Controlled blood pressure)</li> <li>• A target of 60% of the participants enrolled in telephonic counseling, who report a baseline blood pressure value greater than 140/90 mm Hg, will reduce their blood pressure to less than, or equal to, 140/90 mm Hg or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate after being on service for at least 6 months</li> <li>• Increase in member adherence to treatment guidelines and improved self-management skills as evaluated by self-reported information and through claims-based metrics</li> </ul>
<b>Obesity<sup>1</sup></b>	<p><b>Adult Weight Management</b></p> <ul style="list-style-type: none"> <li>• Weight loss of 5-10% of body weight for those who participate in the program for a minimum of 12 months</li> <li>• Improved Physical Activity: Duration 150+ min/week</li> <li>• Increased positive behavior change regarding healthier food/nutrition choices, such as increased number of fruits, vegetables, and whole grains and increased hydration (self-reported)</li> <li>• Improved self-awareness and knowledge of healthy weight loss methods (self-reported)</li> </ul> <p><b>Pediatric Weight Management Pilot</b></p> <ul style="list-style-type: none"> <li>• Child's age and BMI percentile</li> <li>• Nutritional metrics: Number of days per week that breakfast is consumed, number of daily/weekly meals eaten at fast food restaurants, number of sugary beverages consumed daily/weekly, number of fruits and vegetables served daily, number of daily/weekly meals/snacks that include dessert or sweets.</li> <li>• Physical activity metric: Positive changes in physical activity.</li> <li>• Activity metrics: enrollment, satisfaction, number of calls, activity on Program's Facebook page.</li> </ul>
<b>Pain Management</b>	<ul style="list-style-type: none"> <li>• Improvement in Oswestry Disability Index to &lt; 20</li> <li>• Adherence to treatment guidelines and improve self-management skills to recover from current back pain episode, prevent subsequent back pain injury and optimize quality of</li> </ul>

Condition	Program Measurements
	<p>life as evaluated by self-reported information and through claims-based metrics</p> <ul style="list-style-type: none"> <li>• Reduced health care utilization related to back pain</li> <li>• Reduced pain medication usage (for members on pain medications)</li> <li>• Improved body mechanics, if muscular related pain</li> <li>• Increased exercise tolerance (duration and frequency)</li> <li>• Improved pain management as measured by average Pain Scale scores</li> <li>• Decreased emergency room visits for low back pain</li> </ul>
<b>Perinatal Substance Use Disorder</b>	<ul style="list-style-type: none"> <li>• Successfully screen 50% of members identified as potential substance users</li> <li>• Improved member engagement through committed development of a recovery plan</li> <li>• Marked reduction in infants born prematurely or with drug exposure by members in our CCMP program</li> <li>• Reduction in NICU withdraw diagnoses</li> <li>• Validation that 100% of participants received written materials and phone based education and support toward recovery plans and available services</li> <li>• Engagement in ongoing SUD treatment and recovery plan postpartum as evidenced by successful completion of care plan goals</li> </ul>
<b>Sickle Cell Anemia</b>	<ul style="list-style-type: none"> <li>• Improved compliance with medication regimen for hydroxyurea</li> <li>• Decreased emergency room visits for pain</li> <li>• Adherence to proper use of analgesics to control pain</li> <li>• Decreased episodes of infection related conditions</li> <li>• Improved attendance at school/employment</li> <li>• Improved preventive care visits</li> </ul>

<sup>1</sup> For example, if the 80% target is not achieved, and the baseline rate was 50%, then the minimal target/compliance rate needed to meet a program's success goals would be 65% ( $80\% \text{ target} - 50\% \text{ baseline} = 30\% \div 2 = 15\% + 50\% \text{ baseline} = 65\%$ ). Either target will constitute successful performance.

**Annual Program Assessments.** LHCC assesses each CCMP's success at least annually based on clinical, humanistic, and economic outcomes. Methods of evaluation include:

- Member engagement in the CCMP program (self-reported and as evidenced by progress in meeting care plan goals)
- Condition-specific indicators (such as Healthcare Effectiveness Data and Information Set (HEDIS) rates and Agency for Healthcare Research and Quality Review (AHRQ) measures)
- Utilization data, such as frequency of ED visits or inpatient admissions/readmissions
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
- Reported provider satisfaction
- Estimating program cost-effectiveness and savings, and
- Other measures as determined by DHH.

**Ongoing Assessments.** LHCC also collects and analyzes on an ongoing basis clinical, resource utilization, cost, and administrative performance data to monitor program effectiveness. We also monitor member and provider satisfaction as follows:

- LHCC conducts annual and periodic surveys of member satisfaction. We first survey CCMP members following completion of the Initial Health Assessment (IHA) and first follow-up call or home visit. We outreach to members annually based on their initial enrollment date. We ask about

overall satisfaction with our program, program staff, usefulness of information offered, and members' ability to increase self-management of their chronic condition.

- LHCC conducts semi-annual provider satisfaction surveys for providers related to their experience with the CCMP, using a mailed questionnaire. Our Provider Relations staff also annually conduct a comprehensive provider satisfaction survey that includes questions about the CCMP.
- For both members and providers, QI staff continually evaluate feedback and Grievances to identify needed program improvements. They use filed complaints as well as feedback given to Case Management Team staff and other plan staff, and feedback offered during our Member, Provider, or Community Advisory Committees. They may also use focus groups to help clarify any issues and identify possible solutions.

Outcome Highlights. As demonstrated below, LHCC will offer proven CCMP programs to successfully meet the needs of our Louisiana members and address state priorities.

**Table E. Examples of Program Success**

Program	Highlights
<b>ADHD</b>	HEDIS scores for our Indiana affiliate in CY2013 (the last HEDIS reporting period) for the continuation and maintenance phase of the program were 13.01 percentage points higher than our established benchmarks for success. For example, our affiliate scored 58.66% on the HEDIS metric "Follow up Care for Children Prescribed ADHD Medication", which was higher than our NCQA benchmark goal of 45.65%.
<b>Anxiety</b>	Our Missouri affiliate focused on the significant comorbidity of anxiety and depression. For the period March 2013-April 2014, it achieved a drop in average PQ9 scores by 23%, indicating reductions in depression symptoms due to program interventions.
<b>Asthma</b>	For LHCC in CY 2013: <ul style="list-style-type: none"> <li>• Utilization of controller medications increased from 35% in 2012 to 42% in 2013</li> <li>• Peak flow utilization increased from 11% in 2012 to 20% in 2013</li> <li>• Members with asthma reporting decreased symptoms increased from 15% in 2012 to 33% in 2013</li> </ul>
<b>Congestive Heart Failure</b>	For LHCC in CY2013: <ul style="list-style-type: none"> <li>• ACE/ARB use among participants increased from 55% in 2012 to 66% in 2013</li> <li>• Blood pressure screenings and control both improved year over year. BP screenings increased from 9% to 37%. Control levels (= &lt;130/80) went from 8% to 31%.</li> <li>• LDL-C screenings increased among participants from 24% in 2012 to 55% in 2013</li> </ul>
<b>Depression</b>	Across Centene affiliate plans that used this program March 2013-April 2014: <ul style="list-style-type: none"> <li>• Average PQ9 scores dropped by 23%, indicating reductions in depression symptoms.</li> <li>• In our Kansas affiliate, 40% of Depression CCMP members in Q2 2013 achieved clinical improvement, and had medical inpatient costs that were half that of members who were assessed but did not actively participate in Depression CCMP.</li> </ul>
<b>Diabetes</b>	For LHCC in CY2013: <ul style="list-style-type: none"> <li>• ACE/ARB use among participants improved from 41% in 2012 to 64% in 2013</li> <li>• Annual Retinal Exams increased from 41% in 2012 to 86% in 2013</li> <li>• Blood pressure (BP) screenings and control both improved from Q1 to Q4 2013. BP Screenings increased from 9% to 14%, and control levels (= &lt;130/80) from 4% to 11%</li> <li>• Members who reported testing their blood sugar (self monitored blood sugar) increased from 15% in 2012 to 53% in 2013.</li> </ul>
<b>Hepatitis C</b>	Our Centene affiliates in Florida and Illinois implemented their Hepatitis C programs in August 2014 (in partnership with AcariaHealth). Outcome data is not yet available.

Program	Highlights
<b>HIV/AIDS</b>	<p>AHF provides HIV/AIDS chronic care management statewide in Florida for about 9,000 Medicaid members via Florida's fee-for-service program and managed care plans. To date indicators of success include:</p> <ul style="list-style-type: none"> <li>• 77.3% of Florida participants have had at least two HIV-related outpatient visits, which is higher than the national average of 66% of HIV-infected individuals <i>linked to care</i> as measured by the CDC*</li> <li>• 59.2% have had two or more CD4 tests within a year, and 73.2% have had two or more viral load tests within a year, which is considerably higher than the CDC-reported national average of 37% <i>retained in care</i>; and</li> <li>• 93% have been prescribed Highly Active Antiretroviral Treatments (HAART regimen), which is higher than CDC's reported national average of 33% <i>taking antiretroviral medicine</i>.</li> </ul> <p>*CDC, <i>HIV Stages of Care</i>, July 2012: Of all the people who are HIV-infected, only 82% are diagnosed with HIV; 66 % are linked to care; 37% are retained in care; 33% are taking antiviral medication, and 25% are virally suppressed.</p>
<b>Hypertension</b>	<p>For LHCC in CY2013:</p> <ul style="list-style-type: none"> <li>• Blood pressure screenings and control improved year over year. BP screenings increased from 11% to 29%, and control levels (= &lt;130/80) went from 25% to 37%</li> <li>• Proper hypertension medication use (Rx adherence) increased from 44% in 2012 to 61% in 2013</li> <li>• LDL-C screenings increased among participants from 11% in 2012 to 42% in 2013</li> <li>• 4% of members enrolled in coaching quit smoking.</li> </ul>
<b>Obesity</b>	For LHCC in 2013, 53% of participants reported a reduction in their BMI.
<b>Pain Management</b>	<p>For LHCC's Low Back Pain program in CY 2013:</p> <ul style="list-style-type: none"> <li>• ED visits per 1,000 participants decreased from 629 to 459</li> <li>• The number of participants reporting at least a 20% decrease in pain scaled increased from 12% to 33%</li> </ul>
<b>Perinatal Substance Use Disorder</b>	Our Ohio affiliate's "FIRST STEP Addiction in Pregnancy" program received the Ohio Association of Health Plan's (OAHP) Pinnacle Award for Best Practice Health Care Programs in 2014. FIRST STEP integrates our affiliate's Start Smart for Your Baby Program with intensive perinatal SUD disease management components.
<b>Sickle Cell Anemia</b>	For LHCC's Sickle Cell <u>Case Management</u> Program in 2013, the percentage of members taking Hydroxyurea increased 19.6% (from 35.7% to 42.7%)

### Plans to Partner with National, State or Community Foundations

LHCC and Centene build our programs on the philosophy that successful managed care meets member, provider, and State needs by working in collaboration with local systems of care and stakeholders who share our goal of high quality member services and support. National, state, and community organizations – including provider groups, FQHCs/RHCs, school-based clinics, and offices of public health – are often on the front lines of identifying and addressing the wide range of issues associated with chronic care.

LHCC has established and will continue to establish partnerships with a spectrum of national, state, and local resources to identify and provide high quality member educational materials and tools; access to nearby services and screenings, support groups, and peers; and localized reinforcements of healthy habits and self-care. These partnerships include:

- National Urban League, New Orleans
- American Heart Association
- Sickle Cell Anemia Foundation of Baton Rouge
- National Association of the Mentally Ill

- National Hemophilia Association
- LA Tobacco Quitline/Smoking Cessation Trust
- FQHCs
- Acadian Ambulance
- Puentes New Orleans
- David Raines Community Health Center
- YMCAs
- Local schools
- Boys and Girls Clubs

We plan to develop additional partnerships and collaborations with organizations such as the following:

- Louisiana State University and its departments and facilities to establish a telemedicine program
- Office of Public Health to more closely collaborate on chronic care initiatives, such as those in their Chronic Disease Prevention and Control Unit programs
- Lady of the Lake Hospital and other providers who have mobile units through which we can expand access to health screenings in underserved areas
- Families Helping Families
- Alcoholics Anonymous and Al Anon
- The HIV/AIDS Alliance for Region Two, Inc (HAART)
- 504HealthNet, which is comprised of 21 nonprofit/governmental providers in the Greater New Orleans area, to offer them provider training and education about our CCMP programs and how to refer members

*• How recipients will be identified for inclusion into the Chronic Care/Disease Management program, including populations of special interest to Louisiana e.g. reproductive aged women with a history of a prior poor birth outcome and members with Diabetes, HIV, Hepatitis C and sickle cell disease.*

**2013 experience** showed that about **84% of members** who were **contacted by phone or in person agreed to participate** in a CCMP, and **86% who enrolled opted into coaching.**

### Identifying CCMP Recipients – Early Detection and Referral

As described below, LHCC uses a variety of methods and data sources to quickly identify members, including populations of special interest to Louisiana, who may benefit from chronic care management. We have program-specific eligibility criteria and health assessments to identify member needs and readiness for change. We also identify continuity of care needs, such as when a

new member transitions into our plan. We refer high-risk members with co-morbid or complex conditions to one of our specialized Case Management programs.

**New Member Health Risk Screening.** Early identification of physical and behavioral health conditions and relevant psychosocial issues is key for improving outcomes. LHCC's Health Risk Screening (HRS) tool for newly enrolled members asks for current and previous health-related conditions and medication use, and enables staff to identify potentially qualifying risk factors for CCMP.

To detect poorly managed chronic conditions upon plan enrollment, LHCC uses a multifaceted approach to encourage HRS completion within 90 days. Members may complete the HRS during the New Member Welcome Call. Members may also complete the HRS online via the Member Portal by mailing a hard copy found in the Welcome Packet that includes a return envelope with prepaid postage, or over the phone with assistance from NurseWise or Member Services staff. For example, during any member call, our NurseWise or Member Services staff may determine, through alerts in our Member Relationship Management (MRM) system, that the member has not yet completed the HRS and offer to help them complete it. If we are unable to contact the member telephonically and there is indication that the member is at high risk, we may send an MCR to the home to complete the HRS.



**Predictive Modeling.** LHHC uses Centelligence™, Centene’s innovative predictive modeling solution, to assist in identifying candidates for CCMP. Centelligence™ incorporates a suite of best-in-class, multi-dimensional predictive modeling and case management analytics tools. At the population health management level, Centelligence™ enables LHCC plan staff to use eligibility, medical, behavioral and pharmacy claims, (including historical claims data from DHH or the SMO) demographic data, and lab test results to identify risk and needed health care services for our members. Centelligence™ also enables LHCC staff to identify and stratify a member’s health risk, which helps us identify appropriate interventions and timeframes for outreach, assessments, and appropriate interventions. LHCC uses predictive modeling to identify issues such as:

- Over-utilization of services, including ED visits, inpatient admissions, or poly-pharmacy
- Under-utilization, such as failure to adhere to evidence-based and clinically accepted practices for defined diseases (such as members with diabetes with no HbA1c test claims)
- Reproductive-aged women with a history of poor birth outcomes (such as those with previous birth-related intensive or specialized perinatal care claims)

**Biweekly Modeling.** We generate predictive modeling reports twice a month covering the entire LHCC membership because member health and social situations change. For example, a member may receive a new diagnosis or experience an exacerbation of a previously well-controlled condition. This predictive modeling frequency and approach enables staff to timely identify changes in needs and risk levels, and identify members for Chronic Care Management before their condition escalates.

**Referrals.** *Staff* identify members through information collected through our prior authorization processes and ED utilization reviews, case management assessments, MCR home visits, drug utilization reports, NurseWise communications with members, inpatient census reports, and contact with members prior to discharge. *Providers* may refer members and request specific interventions. *Members (or their caregivers)* may self-refer to our CCMP. We inform members of CCMP and Case Manager services and how to request enrollment in our Welcome Packet, Member Handbook, and Member Portal. NurseWise, MCR, and CSR staff may also inform members/caregivers of our CCMP programs and assist with enrollment.

*In Q1 2015, LHCC will offer a mobile app that will enable members to complete our HRA via a desktop, mobile, or tablet device.*

**Continuity of Care.** For new members who were receiving CCMP services with their former MCO or fee-for-service (FFS) Medicaid (such as shown on previous claims information, through our HRS or other contacts and assessments) our IC Team staff contact the previous MCO/FFS representatives for information about chronic care services, including preferred contact mode and times, program status and goals, treating provider(s), and utilization. LHCC staff also will comply with all continuity of care requirements, such as those specified in 6.29-6.36. For more details about LHCC’s Continuity of Care processes, please see our response to Section L.1.

### Program Specific Assessments

Once we identify members as CCMP candidates, we give them written information by mail or in person that describes the program for which they qualify and information about next steps, such as how to enroll, and needed follow up phone calls and assessments.

We attempt to contact all CCMP candidates by phone following an initial mailout to complete an Initial Health Assessment (IHA). The Health Coach/Case Manager attempts to contact the Member three or more times, calling on different days of the week including weekends, and at different times of day, to maximize the likelihood of successful contact. They may mail a postcard asking Members who cannot be reached by phone to call our toll-free number to discuss their health. On a case-by-case basis, an

MCR also may conduct the assessment face-to-face in a member's home or provider office if we are unable to successfully contact a high risk member by phone.

Because a holistic picture of the member's needs and preferences is not fully captured with the HRS and claim information, we conduct condition-specific initial health assessments (IHAs). As needed, we conduct a more comprehensive Health Risk Assessment (HRA) or other assessments, such as for evaluating symptoms of depression. Our Health Coaches or other IC Team staff contact potential CCMP participants for an IHA within 2-30 days of referral/identification, and often within 7-14 days for members who we identify as high risk or having a BH condition.

Our IHAs and HRAs are holistic in design. They target the relevant condition but also feature open-ended questions that foster an understanding of the individual's clinical co-morbidities, including BH conditions and psycho-social status. The IHAs/HRAs evaluate for knowledge deficits or gaps in care according to nationally recognized evidence-based guidelines (such as evaluating whether members with diabetes are getting their hemoglobin A1C checked at least annually). These assessments also help us determine the member's readiness for change, which is essential in determining the appropriate frequency and types of contact and other interventions by Health Coaches/Case Managers. See our description of our Case Management model below for more detail about our risk stratification and contact frequencies and re-assessments with every member contact.

### Clinical Eligibility Criteria

In addition to determining program eligibility through activities such as assessments, predictive modeling, referrals, etc., each CCMP program has specified diagnosis-based eligibility criteria to help focus outreach. When used in tandem with our assessments and risk stratifications, these criteria help our Case Managers and Health Coaches develop targeted interventions and appropriate outreach frequencies. The eligibility criteria include, but are limited to the criteria shown below:

**Table F. CCMP Eligibility**

Program	Criteria
<b>ADHD</b>	Members diagnosed with ADHD aged 6-17 who have begun taking ADHD medications or are over/under-utilizing medication
<b>Anxiety</b>	Aged 18+, scoring 10 or above on the General Anxiety Disorder (GAD) 7 symptom scale
<b>Asthma</b>	Two or more asthma claims; any asthma-related ED visit or inpatient stay; no COPD claims, yet three or more inhaled bronchodilator prescriptions; use of both oral anti-inflammatory and inhaled anti-inflammatory prescriptions; 8 years old or under with three or more oral bronchodilator prescriptions.
<b>Congestive Heart Failure</b>	Age ≥30 and any of the following: 1+ CHF-related inpatient days, 2+ CHF claims
<b>Diabetes</b>	One or more primary or secondary diabetes, diabetes complications claims, or pharmacy claims show one or more medications for prescription glucose regulators
<b>Depression</b>	Aged 18+, scoring positive on the depression symptoms scale
<b>Hepatitis C</b>	Any member diagnosed with Hepatitis C or identified by PA requests for Solvaldi® or Olysio® for the treatment of Hepatitis C. (Member participation will discontinue after completion of their course of treatment or therapy.)
<b>HIV/AIDS</b>	Any member diagnosed with HIV/AIDS
<b>Hypertension</b>	One or more primary hypertension ED visits and/or inpatient days, 2+ primary or secondary hypertension claims, and 1+ claims for anti-hypertension medication
<b>Obesity</b>	<b>Adult Program:</b> At least 18 years of age with a body mass index (BMI) ≥ 25 or a history of BMI ≥ 25 with need for weight maintenance support <b>Pediatric Pilot Program:</b> the child's BMI-for-age ≥ 85th percentile
<b>Pain Management</b>	For Back Pain: One thoracic or lumbar dorsopathic, sprain/strain or non-allopathic lesion claim with an amount paid in excess of \$2000, or two thoracic or lumbar

Program	Criteria
	dorsopathic, strain/sprain or non-allopathic lesion claims within the past twelve months For Other Chronic Pain: Members reporting pain that affects quality of life (usually lasting more than 12 weeks) with a correlating diagnosis (such as Cancer, Sickle Cell Disease, HIV/AIDS, and others), repeat ED or specialist visits for pain, or pharmacy claims for multiple pain management medications.
<b>Perinatal Substance Use Disorder</b>	Any pregnant member or new mother identified with substance use disorder
<b>Sickle Cell Disease</b>	Diagnosis of Sickle Cell Disease with demonstrated gaps in medication adherence or identified at risk of non-adherence, and pain and hydration exacerbations

**Eligibility for Other Programs.** All CCMP participants may be enrolled in other supporting Case Management or CCMP programs, for example, in both our diabetes and depression CCMP for members with co-morbid conditions. Members with highly complex conditions, including hot spotters, may be enrolled in both our Case Management Program and in our CCMP Program that addresses their primary chronic condition. The Case Manager is the clinical lead, and the Health Coach assists with chronic care management as needed.

We offer *all pregnant members, including members with histories of poor birth outcomes*, enrollment in our *Start Smart for Your Baby®* (Start Smart) pregnancy management program, *in addition to CCMPs* that address her chronic conditions. The Start Smart Program promotes education and communication among pregnant members, Case Managers, and physicians to ensure a healthy pregnancy and first year of life for babies. The program is modeled on Centene’s program, which received the 2010 URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, it was named an NCQA Best Practice.

**• How you identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program.**

## Identifying Disease States/Recipient Types for CCMP

**Annual Population Assessments.** At least annually, and in accordance with NCQA standards, LHCC’s Quality Improvement (QI) staff assess the entire member population and relevant subpopulations (such as ABD and 1915(c) waiver participants) to determine whether our Case Management Program, including our CCMP, is meeting their needs. We also identify opportunities for improvements, such as the potential to reduce unnecessary costs or to improve outcomes.

Our Medical Directors and QI staff identify disease states/conditions and/or recipient types for CCMP by evaluating utilization data, condition prevalence, and member demographics such as gender, ethnicity, race, and primary language. They evaluate these factors against clinical practice guidelines (CPGs), trends, benchmarks, and goals from recognized entities such as DHH, Centers for Medicare and Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ), professional medical organizations (such as the American College of Cardiology), and peer-reviewed clinical studies. We also consider member, caregiver and provider input. For example, we may receive their feedback from their participation in advisory committees; in dialogue with IC Team, Member Services, or Provider Relations staff; or through satisfaction and other survey results. Our Quality Assessment and Performance Improvement Committee (QAPI Committee), which reports directly to our Board of Directors, reviews these evaluations and based on this information LHCC may decide to:

- Add a new CCMP or phase out an existing one
- Modify IC Team staffing ratios or add new team members

- Enhance training for IC Team and other staff
- Enhance the type and number of interventions and community collaborations to better address members' needs.

**CCMP Program Rationale.** Using our multi-factored analysis, LHCC identified the following disease states/conditions for our planned CCMP programs because they are conditions that are prevalent in our membership and for which:

- If left unmanaged, there is a high probability of exacerbation, complications, declining quality of life, and avoidable inpatient and ED utilization
- Costs can be reduced and quality of life improved with the use of optimal outpatient care, and engaging, educational, and clinically-proven techniques and tools to support and motivate members to make and sustain healthy choices; and
- LHCC can help meet Louisiana needs and priorities.

For example we will be adding a CCMP for ADHD based on data analysis that revealed amphetamines, a class of ADHD medications, ranked second highest in LHCC's drug expenditures in Q2 2014 with an average spend of over \$450,000 per month. Without CCMP support to members and their caregivers, these members would be at higher risk for specialized BH care, including inpatient care, and preventable medical expenses associated with poorly managed co-morbid PH conditions caused by the BH condition.

*How you identify members who require in person case management services.*

### Identifying Members for In-Person Case Management

LHCC provides in-person Case Manager and Health Coach contacts to engage members in care; educate members and caregivers on the use of medical devices and supports; and assess the home environment, such as for allergy triggers or safety issues. Below we describe the multiple ways we identify members and opportunities for in-person case management.

**Continual Assessments.** We assess members during initial outreach and with each Health Coach/Case Manager contact. Through our assessments, care planning, and interventions we identify:

- High-risk members in our asthma and diabetes programs for home visits. In these programs, Health Coaches/Case Managers offer at least one home visit to educate members and caregivers about self-care, assess member condition and status, and/or identify and assess barriers or risk factors in the home environment.
- Members and caregivers who may need in-person help to learn how to use and clean new equipment and devices
- An increase in symptoms, which may warrant in-person contact to conduct additional assessments or to educate about self-care
- The need for member/caregiver assistance during their provider office visits, such as helping them understand physician instructions, and helping them identify and ask for more information regarding self-care or treatment options. Our Case Managers will accompany members to office visits as needed.
- The need for in-person case management while a MCR is visiting the member in the home or hospital. MCRs notify the member's Case Manager or Health Coach as appropriate.

**Direct Member Requests.** Regardless of risk level, members in all of our CCMP programs may request a home visit for an assessment or other needed assistance, such as with self-care.

Referrals from Providers and Other Partners in Care. We identify in-person case management needs through referrals from providers and our community-based health care partners. For example the paramedics in our current Community Paramedicine Pilot program and USMM physicians in our future In-Home Primary Health Care Delivery Program (described above). Information from the paramedics and USMM physicians will help us determine appropriate CCMP interventions, including the delivery of in-person case management or health coaching.

**The Community Paramedicine program** is currently targeted for children with asthma living in New Orleans and operates in partnership with Acadian Ambulance. It is in addition to our health coaching and other program interventions. We refer identified eligible members to Acadian, and Acadian outreaches to the member and the member's PCP to obtain their commitment to engage. Upon member enrollment, a paramedic visits the member's home to conduct an assessment that focuses on environmental triggers, knowledge of medications and compliance, and level of support available. Acadian also will send a paramedic to the home, as needed, in response to member/caregiver calls for assistance in addressing urgent asthma symptoms or to transport the member to an appropriate higher level of care, such as an urgent care center. We plan on expanding this program, if successful and feasible, to other parts of Louisiana to help us care for members with other chronic conditions.

***Plans to integrate with existing resources/programs in Louisiana as well as your plans to have case managers "on the ground" in addition to telephonic case management***

LHCC's focus on serving the whole member includes collaborating and integrating with the community organizations and resources that are familiar to members, and whose objectives emphasize patient education and access to quality services. We have regionally based Case Managers, some of whom are located in provider settings or who travel with the member to their doctor visits. Also, throughout the year, our MCRs participate in local community events. We encourage MCRs and all of our staff to build relationships with organizations in the communities in which they live.

### **Partnering and Integrating with Existing Community Resources**

As shown throughout our proposal, LHCC identifies and collaborates with existing resources/programs to support all aspects of member care. Below are a few examples specific to LHCC's CCMP.

**National Organizations and Their Louisiana Chapters.** We will continue to support and find ways of integrating with national organizations with which we have already built strong relationships. For example,

- LHCC sponsored the American Heart Association Go Red Luncheon in 2013.

#### **LHCC IN ACTION...**

*"It was our decision to establish a relationship with Louisiana Healthcare Connections based on our positive experiences with them.... We especially value their efforts in the following areas:*

- *Strong billing support with efficient claims payment*
- *Ongoing Provider education and continuous support*
- *Robust case and disease management coordination and programs*

*I recommend Louisiana Healthcare Connections because they have repeatedly demonstrated themselves to be knowledgeable, responsive, and reliable."*

Asbel Montes, VP Government Relations and Reimbursement, Acadian Ambulance Service, Inc. 9/10/14



- We have been a strong supporter of the Sickle Cell Foundation.
- Our MCRs helped organize and promote LHCC staff participation in a Sickle Cell Awareness 5K Walk/Run in August hosted by the Sickle Cell Anemia Foundation of Baton Rouge.
- LHCC sponsored the event, and 42 LHCC staff participated. We have also provided financial support for Southwest Louisiana Sickle Cell Anemia, Inc., which provides genetic testing and counseling, case management and behavioral health support for individuals and families.
- Our behavioral health affiliate, Cenpatico, has partnered with the National Association of the Mentally Ill (NAMI) on several of their national projects, such as their national conference, and is a regular sponsor of state NAMI walks and other local activities.
- AcariaHealth, our specialty drug affiliate, has partnered with the National Hemophilia Foundation and the Hemophilia Federation of America at national and local levels to assist families with information, resources, and education.

LHCC continually seeks opportunities to establish relationships with organizations that benefit our members. For example, we will be outreaching to organizations such as Families Helping Families for members with ADHD and/or special needs to enhance our programs with their educational information or referrals to their parent- to-parent workshops. We will approach Alcoholics Anonymous and Al Anon for enhancements/collaborations, and support services for our members and their families who are identified for our perinatal SUD program.

**Local Providers.** LHCC will offer a telemedicine program in partnership with Louisiana State University (LSU) Hospital Services Division, LSU Health Science Center New Orleans, LSU Health Care Network Clinics, and possibly LCMC Integrated Health System. LHCC will rely on LSU's 12-year experience in telemedicine to help us identify and develop our telemedicine network. We will focus on providing specialty care to meet our members' acute and chronic care needs, and create a telemedicine network that includes, for example, specialists in pediatric pulmonology (for severe asthma and other lung conditions), and pediatric endocrinology (such as for diabetes).

We will continue to work with providers to offer screenings important to chronic care management. For example, in 2013 MCRs worked with La Raza's Louisiana Affiliate, Puentes New Orleans, and A Community Voice (an organization of community members representing families, the elderly, women, children, and workers in low-income communities) to help them organize and coordinate with one of our providers, EXCELth, to bring a mobile clinic to La Raza's community health fair so that participants could much-needed dental screenings, which support members' ability to consume nutritious meals.

Our Floridan affiliate recently launched a modified depression CCMP in Jacksonville, FL, in partnership with FQHC locations. This unique program used the IMPACT evidence based guidelines developed by the University of Washington, and was featured by US Department of Health and Human Services as a best practice. LHCC will explore similar partnerships with Louisiana providers to enhance services for members.

We will seek collaborations with practices that include mobile units and other community partners to reach people in rural areas and ensure that communities can access preventive and chronic care-related health screenings, such as cholesterol, blood pressure, weight assessments, HIV and HbA1c.

#### LHCC IN ACTION...

*"Through sponsorship of the "Sickle Cell Community Walk/Run" we have been able to provide outreach materials and client informational materials. Additionally, we have been able to provide additional supportive services to individuals challenged with sickle cell disease as described on our website...."*

Lorri Burgess, Chief Operating Officer, Baton Rouge Sickle Cell Anemia Foundation, 9/10/14

As mentioned earlier, our Community Paramedicine program provides real time support for children with asthma, including triage, home assessment and appropriate redirection, with a goal of decreasing unnecessary ED visits and inpatient stays.

**State Organizations.** We will continue to train all IC Team staff and Customer Service Representatives (CSRs) to educate and refer members who express an interest in quitting, or who are identified as smokers, to the Louisiana Tobacco Quitline and the Smoking Cessation Trust resources. Our Case Managers/Health Coaches will continue to incorporate into a member's individualized care plan the program's Quit Plan and supports.

LHCC will explore ways of partnering with DHH activities specifically related to chronic care, such as with their Chronic Disease Prevention and Control Unit, the Diabetes/Obesity Prevention and Control Program, the Asthma Prevention and Management Program, the Heart Disease and Stroke Prevention Program, and the Louisiana Health Disparities Collaborative, which aims to build capacity among the FQHCs and RHCS to provide quality chronic disease care and reduce health disparities. Our partnerships with these programs, for example, could include assistance with organizing or sponsoring an event, sharing health-related information with members and the general public, and sharing best practices or state initiatives with our network providers.

**Community Organizations.** LHCC collaborates with a wide variety of community organization to leverage existing resources and programs to benefit our members. Programs and activities we have implemented with our community partners to achieve CCMP program goals include but are not limited to the following.

- Lunch and Learns help educate members about how to eat healthy while on a budget and how to reintroduce physical exercise in their lives. This program is especially helpful for members in our CHF, Hypertension, and Obesity programs. For example, we have sponsored and facilitated Lunch and Learns in Regions 2, 4, and 6 for seniors at the local YMCAs, some of whom were LHCC members who may have been referred by IC Team staff.
- Our Healthy Snack Attack program with local schools teaches kids and their parents about nutritious and light snack preparations. Materials may include our Darby Boingg Children's Cookbook and accompanying parent guide.
- Our annual sponsorship and assistance with the Kiddie Olympics in Regions 6 and 7 (in partnership with the YWCA, Northwestern State University, and Einstein charter schools) promotes the benefits of exercise.
- Other nutrition and fitness collaborations include our How Does Your Garden Grow program in Regions 6,7, and 8, in which we work with local schools and help children plant fruit/vegetable gardens, and Be Fit in regions 2, 3, 6, and 7 in collaboration with RKM clinics, YMCA, Boys and Girls Clubs, and Ryan Elementary.

### Case Managers On the Ground

We currently have Case Management staff onsite with providers such as Affinity Health Group (a large group

#### LHCC IN ACTION...

*"Because of our strategic partnership with Louisiana Healthcare Connections, we have received:*

- *Support in billing and claims payment*
- *Provider education and support*
- *Care coordination, which made referrals and authorizations easier to obtain*
- *Case and disease management coordination and programs*
- *In House assistance with Social Workers and patient coordination*

*We truly value our relationship with them and our ability to work together to develop creative solutions to improve access and quality."*

Michael C. Echols, Director of Business Development, Affinity Health Group

practice in Monroe) and at the *David Raines Community Health Center in Shreveport*, which has allowed us to provide in-person case management to our members who receive services from these providers. In addition, we are working with Affinity to enhance the clinical integration of our CCMP services with their primary care services through additional onsite LHCC staff who will provide CCMP outreach and coaching to our members assigned to an Affinity PCP.

LHCC will pilot a program with *North Oaks Pediatrics, Children's Clinic of Southwest Louisiana, and Pediatric Center of South Louisiana* to improve behavioral health integration. LHCC will give an unrestricted grant for these providers to hire an LCSW for behavioral health intervention and counseling. This initiative will support more accurate diagnosis and treatment for behavioral health disorders such as ADHD.

In addition, we have Concurrent Review Nurses (CRNs) onsite in 17 hospitals, and we are working to add five more hospitals with onsite CRNs. These onsite CRNs facilitate communications between the LHCC and hospital staff to ensure the timely delivery of needed care and the coordination of services post-discharge.

• ***How the Chronic Care/Disease Management program will coordinate information and services with the PCP.***

Provider involvement in member management is key to CCMP success. LHCC coordinates services and information with PCPs and other providers to achieve optimal member outcomes and quality of life. This includes BH care management because many members with symptoms of depression and ADHD often turn to PCPs rather than seeking a mental health provider.

Our new Director of Case Management also brings first-hand experience with CCMP coordination with PCPs. Since 2012, she has worked with the shared savings plan, CHS (now assigned to LHCC) in case management, chronic care management and quality programs.

### **Provider Education**

Fundamental to CCMP coordination is ensuring PCPs understand CCMP programs and processes, including their role in directing and supporting chronic care management for members on their panel. Through initial and ongoing training, Provider Relations Specialists (PR Specialists), Medical Directors, and, as needed, our Pharmacy, Case Management, and other clinical staff educate providers about CCMP, our IC Team model, issues, and best practices.

Additionally, our PR Specialists provide in-person training to providers and their staff on CCMP components, including clinical guideline and best practice updates when applicable. Our quarterly Provider Newsletter, NetworkConnect, provides refresher information about the CCMP, program enhancements, CPG updates, relevant new technologies, and stories that highlight provider successes in improving health outcomes.

### **Coordinating Services**

Upon member enrollment in CCMP, the Health Coach or lead Case Manager sends a program introduction letter to the PCP notifying them of the member's enrollment and the support we offer. The letter includes instructions on how to use CCMP services and how the Health Coach/Case Manager intends to work with the practitioner's patients. They also request PCP input on the proposed care plan that was developed from our assessments. For our Obesity Program, this includes approval by the PCP for exercise. We also send them clinical practice guidelines, such as from the National Asthma Education and Prevention Program, for their members with asthma who are in our CCMP.

The Health Coach/Case Manager updates the PCP with information from member monitoring, such as changes in health status, gaps between recommended and actual care, and any treatment plan inconsistency with relevant evidence-based guidelines. We encourage providers to request specific interventions at any time. Health Coaches/Case Managers also facilitate communications and information, as needed, between the PCP and the member's other providers.

For potentially urgent situations, the Health Coach/Case Manager call the PCP and send the PCP a Medical Alert Fax. IC Team staff and our Medical Directors communicate directly with the PCP (or other treating providers, including behavioral health) as often as required.

**Innovative Service Coordination Supports.** LHCC will coordinate with large provider groups place Social Workers or RN Case Managers onsite to enhance care coordination and service delivery for both members and providers. They will also be an immediate point of contact for any questions members or providers may have about CCMPs, strategies, and CPGs. Our Case Managers will also accompany certain high risk members to doctor visits to help them understand their condition and recommended treatments.

Our Transition of Care (TOC) Team of RNs, BH clinicians, and Social Workers handle care transitions for our most vulnerable, high acuity CCMP members at risk of readmission, using evidence-based practices to arrange and ensure follow up care and reduce readmissions. TOC Team staff coordinate with CCMP Health Coaches/Case Managers as needed. For example, they work with the member, provider, and Health Coach to make any necessary changes in the member's care plan and interventions to help the member resume self-management of chronic conditions. This enhances care coordination with PCPs and other providers by ensuring members have all needed services and supports post-discharge, including follow-up visits.

**SafeLink and Connections Plus®.** LHCC has partnered with Safelink to provide free cell phones to our members. This federal program provides free cell phones to individuals that are in a certain low-income bracket. Through our partnership, LHCC members will receive the standard 250 minutes per month; however, calls and texts to and from LHCC are free. Additionally, our case management staff can upgrade minutes based on clinical need. When SafeLink is not an option for members, LHCC may offer our Connections Plus program. This program provides pre-programmed cell phones to certain high-risk members or caregivers who lack reliable phone access. The phones provide member access to their providers as well as Health Coaches/Case Managers and NurseWise. Health Coaches/Case Managers may also text members with reminders about their upcoming PCP appointments.

This program received URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award; a 2009 and 2010 Medicaid Health Plans of America (MHPA) Best Practices Compendium Honoree; and a 2011 MHPA Best Practice Award in the Technology Division.

Our PR Specialists, Case Managers, and Health Coaches also provide tools, as needed, to support PCPs in treating their members in our CCMPs, such as clinical decision algorithms and patient counseling materials. We offer toolkits to help with screening for depression, anxiety, substance use, and ADHD, which facilitates the identification and CCMP needs for members diagnosed with these conditions. We also offer an Asthma Toolkit that includes assessment instruments, literature on clinical management, and resources for helping members understand CCMP strategies. We educate providers about Louisiana's tobacco cessation resources, including how to become a certified Fax to Quit Provider.

### **Coordinating Information**

In addition to the supports described above, LHCC coordinates information and services with providers using the following tools and activities.

**Provider Portal.** Our Provider Portal is a secure web-based platform that supports care coordination with capabilities such as authorization submissions, member-related claims histories, and a growing family of *clinical* applications. These clinical applications include: Online Care Gap Notifications (alerting providers to health alerts as well as gaps in care), an Online Member Health Record (including the ability to view a member’s care plan), practice-level clinical quality and cost reports, and CPGs.

In 2015, we are expanding our online support for providers through our online *Practice Improvement Resource Center (PIRC)*. The PIRC will be a well-organized, searchable compendium of best practice documentation, multi-media content, and interactive tools to help providers in all aspects of their practices. The PIRC will support provider diagnosis and treatment of members with chronic conditions as well as facilitate communications with plan staff, the Louisiana Health Information Exchange, and other expert providers through modes such as secure messaging and online forums.

**Provider Profiling.** Our monthly PCP dashboard reports will show provider performance in our Provider Incentive Program metrics, such as measures to support reductions in ED visits, and improvements in screenings such as for HbA1C (for members with diabetes) and for HIV. These profile reports help encourage PCP engagement in member outcomes and CCMP care planning and interventions.

**Targeted Provider Education.** LHCC staff will provide targeted information to PCPs to promote clinical guidelines and best practices, such as:

- For PCPs who demonstrate potential over-prescribing or inappropriate prescribing of antipsychotics for children, for example, as identified by our Psychotropic Medication Utilization Review program, our BH Case Managers will reach out for more information and, if needed, our behavioral health Medical Director (BHMD) will reach out to help educate PCPs on best practices.
- As needed, our Chief Medical Officer, BHMD or Nurtur’s Chief Health Officer may consult with a provider about other appropriate treatment strategies or chronic care interventions.

**Innovative Information Supports.** To improve PCP oversight of a member’s chronic condition, LHCC recently updated its Provider Portal to flag a member’s high ED visits by displaying an orange flag by a member’s name. When the cursor hovers over the flag, a prompt will state, “Member has had 3 or more ED visits in past 90 days.”

Our Care Gap Alerts feature uses Centelligence™ information technology-based clinical rules and triggers, in combination with member claims and clinical data, to identify gaps in care, such as a need for a check-up or screening related to a CCMP participant’s chronic condition. Centelligence supports PCP coordination by reporting Care Gap Alerts on both Member and Provider Portals (for members, the alerts provide easily understandable nonclinical messaging).

LHCC also intends to participate in health information exchanges as they develop in Louisiana to facilitate our ability to share data with PCMHs and other PCPs. (See Question W.6)

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**Based on feedback from a network provider in Region 4, LHCC enhanced our Provider Portal capabilities to include an online CCMP referral form. This form is an efficient mechanism for providers to notify LHCC staff of members who are non-compliant or may require CCMP enrollment. A submitted form immediately notifies our CCMP staff of members who need health coaching. Since implementing the form earlier this year, our average CCMP referrals per month have more than doubled.**

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*Methods for case management in ways other than simply telephone management. These may include the use of pre-existing community organizations, community hubs, community health workers etc.*

### Case Management Methods Other Than Telephonic

Our CCMP will continue to use a range of methods to effectively engage members in self-care and support caregivers and families.

**In-Person Case Management.** Health Coaches/Case Managers may provide in-person assessments and coaching during in-home and provider office visits. A few examples of our other-than-telephonic case management approach include:

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**LHCC will have 15 locally based RN Case Managers and Social Workers, located in each region of Louisiana.**

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- All Asthma CCMP participants aged five and older who are engaged in coaching receive a peak flow meter (to appropriately monitor their respiratory status) and a spacer (to ensure appropriate delivery of inhaled medications), and in-home education on their use. For some members, we may visit the home to conduct an environmental assessment to identify asthma triggers and barriers to self-care, and/or to assist members and caregivers in using the devices correctly.
- We will offer home visits for certain high-risk members with diabetes, such as those who have been newly diagnosed, have had multiple recent episodes of diabetic ketoacidosis or hypoglycemia, have experienced a recent inpatient admission or ED visit, have an elevated HbA1C, or upon request. During these visits, an RN Case Manager evaluates the member's condition and status, including, by member self-reports, the incidence of skin dryness, foot sores, and injection sites for complications; the quality and correct use of equipment; and need for nutrition education (by observing the kitchen/pantry areas). They also teach and identify knowledge gaps in self-management.
- Our multi-disciplinary Transition of Care Team and concurrent review nurses work with members during and after their hospital stays to ensure they receive needed services and medications. This includes educating them about CCMP programs that are relevant to their conditions, enrolling them in CCMP, and working with their Health Coach/Case Manager in developing an Individualized Care Plan during their stay, if possible.
- Our MCRs contact members at home and in the community, delivering educational material and assistance with identifying barriers to achieving care plan goals. Two of our MCRs are certified in HIV Prevention Counseling and Rapid Testing by OPH, and we are working toward certification of the majority of MCRs by Q2 2015. This certification enables them to provide targeted HIV education about reducing the risk of spreading HIV infections. They will also refer members to Case Managers/Health Coaches for further assistance as needed.
- We have Case Managers stationed in select provider practices, such as with *the Affinity Group*.

**Complex Care Rounds.** During Complex Care Rounds, a multi-disciplinary team of LHCC staff evaluate members with complex or challenging conditions to determine measures that would improve health status, such as recommending treatments, interventions, and care coordination. Integrated Round teams consist of LHCC's Chief Medical Director, Case Management staff, and pharmacy staff. Health Coaches/Case Managers work with the member and their provider on Complex Care Round recommendations and update care plans as needed.

Additionally, LHCC's Case Management Director participates in monthly case rounds with Centene affiliate Case Managers and Medical Directors, which hones our case management expertise and keeps our staff current on best practices and industry trends through discussion of complex cases in affiliate plans.

**Telemonitoring.** In addition to coaching contact and other interventions, high-risk members enrolled in our CHF program may be eligible for in-home telemonitoring, which helps the member, caregivers, providers, and Health Coach monitor and assist, if needed, in a member's care management. We give participating members a pulse oximeter, blood pressure cuff, and scale that uses wireless technology to enable biometric readings that can be measured in the home and transmitted electronically within seconds to the provider and Health Coach. The software compares the data against thresholds established by the provider or national guidelines. Real-time data enables Health Coaches to work immediately with members and providers to address unfavorable trends. This program also helps reduce preventable use of health services, and improves self-management skills.

**In-home Primary Health Care Services Delivery.** LHCC will contract with U.S. Medical Management, Inc., (USMM), our Centene affiliate and national leader in physician house call medicine, to provide enhanced access to health services and quality of life for our most complex members. Eligible members who choose to participate will receive an Annual Wellness Visit, which includes a Personalized Prevention Plan with realistic treatment goals and necessary referrals to specialty care and community resources.

LHCC recently upgraded our resource guide to a searchable directory. Our Community Connections Resource Guide empowers members to find services based on their needs, and in their own regions of the state.

Our Case Managers/Health Coaches use this database regularly, but now motivated members can also use it to find local community, faith-based, governmental, and advocacy organizations to help with such necessities as housing assistance, obtaining food, and paying bills.

For members who choose to use USMM's physician as their PCP, rather than as supplemental primary care, the physician will schedule visits in compliance with DHH appointment availability standards. Visit frequencies for chronic care will correlate with medical necessity. All members will have telephone access to USMM's on-call physician during the evening and weekend hours for acute concerns, in addition to LHCC's Member call center and 24/7 access to a nurse through NurseWise. USMM provides an integrated, physician-driven comprehensive care management.

This program will help LHCC and the member's provider accurately identify and meet home health care needs, and mobilize other supportive services locally available, in order to improve clinical stability.

**Use of Existing Community Resources.** Our Case Managers, Health Coaches and MCRs will continue to work with a wide

range of community organizations to help members with housing, food, utility, and clothing needs. They also refer to local support groups, such as those offered by the Baton Rouge Sickle Cell Anemia Foundation, to help members maintain their motivation for self-care, to learn coping skills, and to benefit from the support of others challenged by the same issues. LHCC helps members access needed social services and assistance by connecting them to organizations such as Catholic Charities Disaster Assistance Program, Habitat for Humanity and Councils on Aging.

Our HIV/AIDS RN Case Managers will also work with Case Managers and other staff at local AIDS Services Organizations such as the Baton Rouge AIDS Society to ensure members get all needed care and supports. LHCC also will join the HIV/AIDS Alliance for Region Two, Inc. (HAART) to ensure member access to their broad continuum of care in addition to our benefits and chronic care management services.

We will strengthen our working relationship with OPH and its clinics, to better serve our members and the needs of their communities. For example, we will work closely with OPH offices in serving our members who have, or may be at risk of contracting, HIV/AIDS, such as by paying for HIV/AIDS screenings for members who may not want to be screened by their PCP. Food security is another big issue with our members, and our case management/CCMP programs will access OPH offices for training about the WIC program and ways to collaborate.

**Other Methods and Strategies.** Our CCMP case management methods also include all of the member engagement strategies described below.

**• *How you engage patients (in person, mobile apps, telephonic) and explain your model of case management including what types of personnel (lay health workers, nurses, social workers) are providing case management.***

### **Staffing, Strategies and Resources for Fully Engaging CCMP Participants**

LHCC engages members and caregivers to participate in and support CCMP strategies using multi-faceted components that provide a comprehensive set of strategies to meet each member's unique situation and motivation. These components include:

- Trained and Culturally Competent Staff
- Inclusive Assessments and Care Planning
- Multiple Educational Formats
- In-Person Assistance
- Member Incentives, and
- An Extensive Array of Telephonic and Online Technologies

**Trained and Culturally Competent Staff.** LHCC's success with engaging members and caregivers begins with our Case Management Model and our expert, culturally competent staff. Our Case Management Model is built upon an integrated, multidisciplinary team to ensure members receive holistic education, encouragement, care, and supports. Our IC Teams address both clinical and nonclinical needs to optimize a member's health. For example, they not only evaluate and address medical needs, but also functional status limitations and barriers to care and self-management, such as impaired cognitive abilities, transportation needs, and the availability and quality of caregiver support.

**Training.** We train our Case Managers to recognize potential needs for both behavioral health and physical health services, which helps them to quickly arrange additional clinical and other supports to successfully assess, educate, and engage members, including referrals to SMO providers as needed.

We will train our BH Case Managers in Trauma-Informed Care so they can recognize trauma's effects, which can be barriers to member engagement, and critical for assisting our members in foster care.

We understand that culture goes beyond race and ethnicity to encompass such issues as poverty and disability, so we involve community-based organizations such as Louisiana Assistive Technology Access Network in training to ensure LHCC staff are familiar with health care access and other issues affecting our members.

**Cultural Competence.** We provide initial and annual refresher training on cultural competence, including how to recognize one's own biases. (See our response to Question T.4 for detailed information on our cultural competency training and monitoring for staff.) Our in-the-field MCRs live and work in the communities we serve, and understand members' customs, beliefs, motivations, and barriers. MCRs may provide in-person education, monitoring, and periodic outreach and assessments to low-risk CCMP participants, and attend community functions to provide health education and outreach. In addition, our

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**We are training all IC Team staff on Motivational Interviewing, Positive Psychology, Member Engagement Skills, and Poverty Competency to identify and discuss chronic care management barriers and appropriate interventions; enlist member and caregiver support of CCMP strategies; and obtain and support sustainable member motivation.**

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staff include Case Managers who are bilingual in Vietnamese, Spanish, and French, which helps them better engage and communicate with members and caregivers.

**Inclusive Assessments and Care Planning.** Members with complex or co-morbid conditions must often follow the direction of several providers. By enlisting the involvement of relevant caregivers and providers, as well as the member, we develop a greater understanding of the barriers to self-care and form agreement and commitment to CCMP strategies and interventions. Below we describe successful strategies to engage members in assessment and care planning.

- Our Case Managers/Health Coaches interview both members (usually teenagers or older) and caregivers during health assessments. We educate them about program benefits and components and their role in treatment planning. Their participation helps us accurately determine health status, health behaviors and medication use, as well as their preferences for support and how to best engage them.
- For members who are minors, developmentally disabled, or cognitively impaired, we always involve the parent(s)/guardian(s). However, we are sensitive to giving teens and members with low developmental or cognitive disabilities a role as the ‘driver’ of the process to encourage their engagement and assumption of personal care.
- We assess caregiver aptitude and needs in managing the child’s condition and environment, and implement interventions that promote their commitment to CCMP strategies.
- Our care planning and interventions include linking members or caregivers to all needed services, including EPSDT screenings, and community services, such as support groups for coping with stress. This promotes involvement by addressing issues that may be barriers to self-care or caregiver care.
- We remind members and caregivers that they may call us at any time if they have questions about the program or how to manage care.
- During periodic follow-ups and coaching, staff re-assess members and caregivers and, as appropriate, adjust the care plan and modify interventions, including the coaching approach.

**Multiple Educational Formats.** We provide CCMP education, interventions, and supports in multiple formats and combinations (such as guidebooks, coaching, equipment, “apps,” and websites) to accommodate members’ range of cultural and linguistic needs, health literacy, reading proficiency, learning styles, and changing circumstances. NurseWise is available toll-free 24/7 to answer questions about a condition or CCMP program. During member contact, our Case Managers/Health Coaches remind members about preventive care and screenings based on relevant CPGs, and the risks associated with progression of their disease.

We also provide hard copy and online educational material. For example, Nurtur’s award-winning quarterly *UpBeat* newsletter offers practical information for CCMP participants, such as minimizing asthma triggers when playing outdoors. Our Member Newsletter HealthConnect is issued to all members, and offers tips on managing chronic conditions and creating healthy habits. See the table below for additional examples We offer educational materials developed by recognized sources, such as ADHD brochures from the American Academy of Pediatrics and *Depression and Diabetes* by the National Institute of Mental Health. LHCC’s online library features a searchable *Krames StayWell* Health Sheet database with more than 4,000 topics explained in clear, simple language with pictures to help members with various levels of literacy understand important health information, including for their chronic conditions. Krames is URAC-accredited and uses a peer-review process and evidence-based clinical practice guidelines to develop their award-winning materials.

We will develop additional online educational material to engage web-savvy members and caregivers, such as online podcasts, interactive calculators, and quizzes that include topics on healthy choices, such as

weight management, how to eat a diabetic-friendly meal at restaurants and in home, and the dangers of smoking.

**Table G. Educational Materials**

Condition	Sample CCMP Educational Material
<b>Asthma</b>	For participants under 10 years of age, we send <i>The Adventures of Boingg &amp; Sprockett Through Puffletown</i> , a cartoon booklet explaining asthma and self-management; and to their caregivers, a companion guide. We provide teenaged participants a booklet called <i>Off the Chain</i> that uses examples they can relate to, such as comparing the annual cost of smoking to items such as video games and sports equipment, and that informs them about famous people with asthma.
<b>Diabetes</b>	We offer a range of age-appropriate communications, such as <i>Adventures from Sugarland</i> (for young diabetics) along with a parent guide; <i>Off the Chain – Diabetes</i> (for teenaged diabetics); and a <u>children’s cookbook</u> on healthy meal preparation, <i>Darby Boingg’s Children’s Cookbook</i> . We also offer diabetes communications for adults, children, and teenagers, and cover a range of co-morbid conditions, such as depression
<b>Obesity</b>	Our new Pediatric Obesity program will have online, age-relevant educational information and resources for children and adolescents seeking help with healthy eating habits and weight control, and will include social media outreach via Facebook.

**In-Person Assistance.** As described above, we identify members who could benefit from in-person visits, such as an asthma symptom assessment by an Acadian Community Care paramedic; coaching and help with device use by a Health Coach; a home assessment by a Case Manager, Health Coach, or Acadian for safety and other potential barriers to care; an assessment of illness or injury, or coaching for “Hot Spotters” or others with complex issues by a USMM physician; or a visit by an MCR to drop off information. Our Medication Therapy Management (MTM) program offers members the opportunity to have face-to-face counseling with a certified MTM pharmacist about their medications and chronic conditions.

**Member Incentives.** We provide incentives for members to adhere to recommended screenings and lifestyle changes. Our CentAccount™ Member Rewards Program promotes personal responsibility by rewarding members for targeted healthy behaviors. Eligible members can earn rewards, such as for completing four diabetes care screenings (to check cholesterol, eye health, HbA1c level and for neuropathy). LHCC loads the reward onto a CentAccount reward card, which members can use at select retailers throughout the state (such as Meijer, Fred’s Super Dollar, Rite Aid, Family Dollar, Super Dollar and targeted for addition soon, Wal-Mart) to buy a wide variety of items, including fresh fruit and vegetables, oral and bathing hygiene items, baby items such as diapers, and some over-the-counter medications not covered by Medicaid. Members can track their incentives on the Member Portal and via our mobile app (described below).

**Technology Supports and Enhancements.** In today’s world, youth and adults alike are growing increasingly comfortable and reliant on computer and telephone technologies. Our analysis indicates that today, many LHCC members and prospective members are regularly online through major social media websites and apps. LHCC’s technology supports and enhancements are designed to reach and engage members who are without reliable communications and transportation, and members who prefer these web or telephonic contacts. We are building on our current technology capabilities to provide additional tools for engaging members in their care. These tools include but are not limited to those described in the table below.



**Table H. Technology Supports and Enhancements**

Tools on LHCC's Website
<p>LHCC's secure Member Portal, with self-service features, offers members the tools they need to help them take personal accountability for their health care. The Portal provides important basic information (such as eligibility and benefit information); helps members understand what they have to do (care opportunities, care gap alerts, health and wellness reminders, and health information specific to the member) to take responsibility for their health; and provides self-service support tools, such as the ability to choose or change their PCP online, print a temporary ID card, exchange secure bi-directional messages with our staff, and manage their Member Portal web account information and communication preferences. Members also can check the status of their CentAccount™ Rewards balance.</p>
<i>Enhanced Interactive Capabilities</i>
<p>In 2015, we are enhancing our website through the incorporation of LiveLook technology, allowing members to click, enter their phone number, and get an immediate call from our Customer Service Representatives. LiveLook also enhances our screen sharing capabilities to mobile devices, allows site visitors to give permission to our CSRs to take control of their web or mobile screen to assist them in learning to navigate through the various functions Member Portal.</p>
<i>Member Access To Their Care Plan</i>
<p>Members can access their care plans on our secure Member Portal so they can track their own care and services. For members with special health care needs, we will provide a Member Health Profile summarizing key information such as diagnoses and medications, to help the member or family, guardian or caregiver (as applicable) understand and track the member's conditions and services rendered. Easy access to care plan and Profile information will enhance member ability to participate meaningfully in directing their own care, such as by alerting a new specialty provider of treatment they are receiving from other providers.</p>
<i>Member Notification of Care Gaps</i>
<p>Starting in Q1 2015, we will expand our Care Gap notifications to allow members who register to use our secure Member Portal the option of receiving email notifications on their mobile device or personal computer as soon as our Centelligence platform identifies care gaps. These e-mails will supply a link for the member to click, prompting them to login to the Member Portal from their mobile device or PC. Once logged in, the member will immediately go to their care gap information.</p>
<i>Community Connections Guide</i>
<p>We are placing our internal community resource guide for Customer Service and Case Management staff on our website to empower members to take charge of their social and other non-covered services needs. This Guide will provide resources such as food pantries, clothes closets, support groups, and other social services, by community, to assist members in identifying potential sources of assistance and support.</p>
Mobile Applications and Other Technology
<p>In addition to continuing support of our mobile optimized website, we are deploying access to key online functions via our comprehensive LHCC Mobile App with an ever-expanding set of convenient interactive tools for mobile devices. Our Mobile App platform is designed to provide a comprehensive and integrated mobile "one stop shop" for our members. As we develop and add new tools, members will be able to access them directly through LHCC's consolidated Mobile App rather than searching for new apps.</p> <p>Our mobile tools are all designed and distributed with a consistent and secure user experience across all platforms, and all fully branded as LHCC mobile tools. Our members will know instantly where to turn to for any assistance. The LHCC Mobile App will be available, free of charge for our members, via the Mobile App Resources section of our public website, as well as the Apple iTunes Store (for iPhone), and Google Play Store</p>

(for Android devices). Selected components of our Mobile App include the following features.
<b><i>CentAccount™ Mobile</i></b>
During the 2 <sup>nd</sup> Quarter of 2015, we will add to our suite of uniformly branded apps with LHCC's Mobile CentAccount™, which gives the member access to their CentAccount rewards information, including status against their health goals and reward points earned to date.
<b><i>Mobile Find-a-Provider.</i></b>
This app uses the native Global Positioning System (GPS) technology included in mobile devices to help members not only find network providers; but automatically get directions to those providers; and allows instant calling to a selected provider.
<b><i>The StartSmart for your Baby® for Bayou Health (Start Smart Mobile).</i></b>
Building on the success of our ConnectionsPlus® mobile phone program, StartSmart Mobile will provide a broad range of integrated interactive tracking tools, self-service functions, alerts, communication capabilities, and accessible resources for pregnant and postpartum members. Powered by our partner Wildflower Health, a leading mobile health technology company focused on women's health throughout their pregnancy with apps serving over 50,000 women, Start Smart Mobile will allow our pregnant members to engage with self-service tools such setting custom reminders for appointments and tracking pregnancy milestones; communicating with a nurse through our 24/7 nurse advice line; and accessing information such as information on more than 50 risk factors for pregnancy complications.
<b><i>MyStrength.</i></b>
Provides tools and resources for managing mental health issues such as depression and anxiety, including wellness assessment, mood tracker, interactive eLearning programs, action plans with suggested steps, structured exercises and daily guidance on topics such as weight and stress management, and personalized expert resources.
<b><i>Health and Wellness</i></b>
<p>A coordinated set of interactive mobile tools to keep our members engaged in their health, with health challenges, personal health trackers, and other online resources, developed in conjunction with our mobile health technology partner, LiveHealthier, Inc. (a global provider of innovative health management apps to engage and keep health plan members healthy).</p> <p>Of particular note, LHCC's <i>Health and Wellness</i> section of our app will include our Mobile Health Risk Assessment (Mobile HRA), allowing a user to complete our HRA via a desktop or mobile device. The HRA question set will be consistent across all devices, but will display appropriately based on the device on which the HRA is being viewed.</p> <p>Data will be securely transmitted and loaded into our TruCare collaborative case management platform, for display within the member's clinical record. The HRA data will also be systematically incorporated into our Centelligence™ analytics platform for integration with other member clinical data in support of reporting and predictive modeling to identify potential member health alerts and care gaps.</p>

## **LHCC's Model of Case Management**

**Qualified Staffing: Integrated Care Teams.** Each CCMP participant is assigned a Case Manager or certified Health Coach, based on their primary disease state or physical or behavioral health condition. The lead Health Coach/Case Manager receives support from other IC Team staff for holistic care coordination and other services as needed, such as our Social Workers, BH clinicians, pharmacy staff, Program Coordinators (for nonclinical and administrative support), and MCRs. MCRs may provide education, monitoring, and periodic outreach and assessments to low-risk CCMP participants, and attend community functions to provide health education and outreach.

Members with multiple conditions may have more than one specialized Health Coach/Case Manager who work together as a team, along with the rest of the IC Team staff. High risk members, or members with complex conditions, will also be enrolled in Case Management, and have a Case Manager oversee the member's entire plan of care and work closely with the Case Manager/Health Coach on the member's chronic care management plan.

Our lead Health Coach/Case Manager responsibilities include:

- Assess members for CCMP inclusion, level of health risk, motivation to change, and barriers to improved condition management
- Work with the member, caregiver, and providers to develop an individualized care plan
- Support member progress toward care plan goals with coaching and other interventions
- Support the provider and the provider/member relationship
- Emphasize prevention of exacerbations and complications by using evidence-based practice guidelines and patient empowerment strategies
- Evaluate outcomes on an ongoing basis with the goal of improving overall health.

**Identification and Assessments.** LHCC uses multiple methods to identify candidates for our CCMP programs. We attempt to contact all identified candidates by phone or in-person to encourage their program participation. We use condition-specific Initial Health Assessments (IHAs) and Health Risk Assessments (HRAs) to help us identify the member's health risks, readiness for change, and the appropriate level and frequency of intervention. Our Case Managers/Health Coaches also assess program participants at every contact, to calibrate our education, coaching and interventions to best meet their needs.

**Risk Stratification and Interventions.** IHAs and HRAs help us refine our understanding of member needs and health risks. After assessment, we stratify members by clinical risk and readiness to change, which helps define frequency and type of contact, appropriate types and intensities of interventions, and other education and assistance, including coordination with local resources. Each CCMP program has its own risk group stratification and intervention criteria, based on member-level assessments of their chronic condition, but in general, members are stratified as shown in the table below.

**Table I. Interventions by Risk Category**

High Clinical Risk	Moderate Clinical Risk	Low Clinical Risk
<ul style="list-style-type: none"> <li>• High risk for hospitalization or recent admissions</li> <li>• Hot Spotters - higher than expected utilization of ED or inpatient stays</li> <li>• Frequent condition exacerbations</li> <li>• Multiple co-morbidities, complications, or special health care needs</li> <li>• Poor medication adherence or recent medication adjustment</li> <li>• Tobacco use</li> <li>• Overweight/obese</li> <li>• Poor knowledge of condition and self-management</li> </ul>	<ul style="list-style-type: none"> <li>• A single chronic condition that is poorly managed or uncontrolled</li> <li>• Infrequent admissions/exacerbations</li> <li>• Medication adherent and stable</li> <li>• Tobacco use in past or in the active stage of quitting</li> <li>• Minimal knowledge of condition and self-management</li> </ul> <p>May also include members who have a high or moderate readiness for change</p>	<ul style="list-style-type: none"> <li>• A well managed/controlled condition</li> <li>• Clinical metrics at/near goal levels</li> <li>• No recent admissions/exacerbations</li> <li>• Medication adherent and stable</li> <li>• No use of tobacco</li> <li>• Weight within desirable range</li> <li>• Engaging in regular physical activity</li> <li>• Actively applying self-management skills</li> </ul>
Health Coach and Case Management Involvement		
• CCMP enrollment offered,	CCMP enrollment offered	CCMP enrollment offered

High Clinical Risk	Moderate Clinical Risk	Low Clinical Risk
<p>along with enrollment in Case Management or Complex Case Management, if needed.</p> <ul style="list-style-type: none"> <li>For members enrolled in <i>Complex Case Management</i>, an RN or BH clinician (depending on primary diagnosis) is responsible for overall direction and coordination of the member's Case Management and CCMP services; the member also has a Health Coach as needed for each relevant chronic condition</li> </ul>	<p>Care plan development and care coordination is lead by the relevant Health Coach or Case Manager</p> <p>IC Team support in care coordination and oversight as needed.</p>	<p>Care plan developed as needed by relevant Health Coach or Case Manager</p> <p>IC Team support as needed in care coordination and oversight</p>
Type and Frequency of CCMP Contact		
Telephonic or face-to-face coaching at least twice a month	Telephonic or face-to-face coaching about once a month (depending on condition and readiness for change) - An average of 4-6 coaching calls/visits per case	Telephonic health coaching as needed and requested - an average of 2-4 coaching calls/visits per case
Educational Interventions For All CCMP Participants, Regardless of Risk Level		
<ul style="list-style-type: none"> <li>Condition and age specific educational materials</li> <li>Postcard appointment reminders</li> <li>Postcards for members we are unable to reach/lost contact with</li> <li>MCR visits as needed to find new contact information or deliver educational material</li> <li>An award winning <i>Upbeat</i> Newsletter mailed every six weeks that contains condition specific topics</li> </ul> <p><b>LHCC also provides education about self-care and needed screenings:</b></p> <ul style="list-style-type: none"> <li>In the Member Handbook, Member Newsletters and on the Member Portal</li> <li>By staff, such as our MCRs or CSRs for nonclinical help, and Case Managers or pharmacists</li> </ul>		

Members may move from one category to another based on changes in their condition. For example, a low-risk member who is hospitalized will be moved to a higher risk level to ensure appropriate follow-up care. Members may also choose their level of intervention intensity. For example, a member whose condition is well controlled may request coaching contacts to maintain control. The assigned Health Coach or Case Manager reassesses risk at each contact to determine appropriate contact intervals and interventions based on clinical acuity and readiness to change.

**Individualized Care Plan Development.** For members enrolled in CCMP, the Health Coach/Case Manager works with the member, other IC Team staff, and appropriate providers to develop a care plan that serves as the basis for improving self-care and condition management. The Health Coach/Case Manager uses information gathered through assessments and during telephonic and in-person member interactions, along with other information, such as utilization data or information from the caregiver, to help the member establish physical health, BH, functional, lifestyle, social, and other goals. The Health Coach/Case Manager also works with members and caregivers to identify barriers to goals, facilitate a readiness for change, promote motivation for sustained behavioral modification, and find acceptable approaches for overcoming barriers. These factors are incorporated within the care plan along with measurable goals and milestones to evaluate progress.

The care plan also addresses the member's role in self-care and action steps, and the use of community resources, such as access to food pantries for improved nutrition. Care plan interventions are designed to improve the member's ability to adhere to their medication regimen and other treatments, and include, as

needed, caregiver interventions, such as assistance with coping with stress. The care plans may also include enrollment in our other CCMP programs. IC Team staff document clinical notes and care plans in TruCare, facilitating timely care coordination and case management by providing eligible team members access to a holistic view of the member's care.

**Reassessments.** We reassess a member's condition, risk, progress, and needs during each contact, and make adjustments as needed to the care plan and interventions, including reassessing the need for in-person case management. Every aspect of the CCMP is designed to provide members with information and feedback about past conversations and progress toward goals. Through continuous, individualized assessment and evaluation, we can adjust our approach to each member's interventions to maximize effectiveness. For example, if monitoring indicates a shift in a member's readiness to change, the Health Coach/Case Manager will determine any refinements needed to interventions. We monitor the following types of metrics using both claims and member-reported data:

- Symptom and functioning improvement
- Decreases in utilization
- Health behavior change
- Progression through the stages of readiness to change
- Medication adherence
- Proper use of medication delivery devices
- Compliance with key measures, such as smoking cessation, immunizations, and condition-specific guidelines
- Progress toward or achievement of personal health behavior or risk reduction goals.

We use medical and pharmacy claims-based data to verify and augment the member-reported information. Because all member information, including assessment results and the individualized care plan, are housed within TruCare, Health Coaches/Case Managers can 'refresh the memories' of our members, reminding them of past responses or agreements to pursue behavior modifications, such as quitting smoking or making dietary changes.